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A State Perspective on National Survey Data on the Uninsured

The following paper presents background information on the national resources available to states and a summary of the strengths and weaknesses of each survey for state policy purposes. Descriptions of surveys are organized by the way in which they are funded: 1) federally sponsored surveys, and 2) privately sponsored surveys.

Behavioral Risk Factor Surveillance System (BRFSS)

<http://www.cdc.gov/nccdphp/brfss/>

The BRFSS was established to provide previously unavailable national data collected on health status and risk behaviors to states. States have the primary role of targeting resources to address behavioral risks and state and local agency participation is essential to achieve national health goals¹. The BRFSS is conducted by states using rolling monthly telephone surveys based on a common sampling methodology and list of core questions, which allow comparisons across states. The core survey instrument includes questions on health insurance coverage, however, states have the option of including a “health insurance module” to collect more specific information on the length of people’s episodes of uninsurance and to determine how satisfied insured people were with their insurance plans. In addition to the health insurance module, states may add their own questions to the survey to address state-specific issues regarding health insurance coverage. Table 1 lists the states who have included the health insurance module and/or their own questions about health coverage in their 1998, 1999, and/or 2000 BRFSS survey.

State Perspective: An advantage for state analysts is that they conduct the surveys, maintain control over the questions in the state-specific modules, and have access to the person-level survey data for ongoing state analysis. Some states have pursued additional sample and developed a stratification that allows them to estimate prevalence for regions within a state. In this regard, the BRFSS is perhaps one model for future federal-state household survey initiatives.

For state health coverage policy, however, the principal drawbacks are the public health focus on working-aged adults; there are no children sampled. Given the federal focus on children through the SCHIP program, BRFSS has not been used to monitor or evaluate national or state health access initiatives. Though the time lag is less than other national surveys, it still takes one year to collect the data and one year to create estimates. Concerns about the telephone

survey's potential for under sampling low-income households have also been voiced, leading to criticism that the BRFSS lacks sufficient data on special populations, populations of color, and city- and county-specific data needed for state health policy initiatives². There is also concern about lack of quality control in the data collection methods as it is difficult to oversee 50 state data collection processes and assess the impact that varied methods have on population estimates.

Table 1. States' Use of the BRFSS Health Insurance Module and/or the Addition of Their Own Survey Questions

States That Used the BRFSS Health Insurance Module (1998, 1999, and/or 2000)	States that Added Their Own Health Coverage Questions to BRFSS (1998, 1999, and/or 2000)
<p>Arizona Idaho Indiana Nebraska Rhode Island Virginia Washington</p>	<p>Alabama Alaska California Florida Hawaii Idaho Illinois Kansas Louisiana Massachusetts Michigan Minnesota Missouri Nevada New Hampshire New Mexico Oklahoma Oregon South Dakota Tennessee Texas Vermont Virginia Washington West Virginia Wisconsin Wyoming</p>

Current Population Survey (CPS)

<http://www.bls.census.gov/cps/cpsmain.htm>

The U.S. Census Bureau has conducted the CPS for more than 50 years. Its primary purpose is to collect labor force data on the civilian noninstitutional population 16 years of age and over. The primary intent of the CPS is to provide government statistics on labor force participation, as well as collect income and employment information. However, each year the March Supplement includes questions concerning health insurance coverage. These questions are asked toward the end of the survey. The March Supplement of the Current Population Survey (CPS) is the most commonly used data source for estimating rates of uninsurance. While the CPS was intended to provide *national* estimates and trends over time, policy analysts began using the CPS to derive *state* estimates of insurance participation.

State Perspective: The CPS sample was not initially designed to produce state estimates for uninsurance rates. For many states, the sample size of the survey is small and the sampling frame includes only a limited number of counties within each state. When states started using the CPS to determine state level estimates of the uninsured, the Census Bureau responded by creating an algorithm for states to use that takes the sample frame into account and recommends using a three year rolling average rather than the rate in any given year. The Census has also responded to states needs by increasing the size of the sample within some states. While increasing the CPS sample has improved the confidence intervals of some of its state estimates, the sample is still too small for detailed state-level policy research (e.g., rates of uninsurance by age, race, geographic region, etc.)

The downsides of CPS are widely known and efforts to fix some of the methodological issues appear to be underway given the new resources allocated with the changes to the Balanced Budget Act included in the omnibus appropriations bill for FY 2000 (P.L.106-113). The federal government has mandated that States report on an annual basis the effect of their State Children's Health Insurance Program (SCHIP) on the number of uninsured children. To help states with this task, the Treasury appropriated \$10,000,000 to the Bureau of the Census to make adjustments to the CPS so that it will produce statistically reliable annual state data on the number of low-income children without health insurance.

Recognizing the inadequacies of the present CPS sample in providing state estimates, the expected adjustments to the CPS include: expanding the sample size used in state sampling units, increasing the number of sampling units in a state, and changing the way the survey determines health insurance status. CPS used to measure health insurance status by asking respondents whether they had coverage from a specified list of sources at any time during the prior year. Those who respond "no" to each source were considered uninsured by default. The new version of the CPS will include an appropriate verification element (i.e., "At anytime during the prior year were you without any form of health insurance?")³.

Despite its drawbacks, CPS provides routine and timely estimates of the uninsured by state providing the only source of comparative information on the uninsured for broad categories of a state's population.

Medical Expenditure Panel Survey-Household Component (MEPS-HC)

<http://www.meps.ahrq.gov/>

The Medical Expenditure Panel Survey (MEPS) is a national survey conducted by the Agency for Healthcare Research and Quality (AHRQ) on the financing and utilization of medical care in the United States. The Household Component (HC) - one of four components of the MEPS - collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for. In addition, information is collected on health insurance coverage, as well as household income, assets and employment.

The panel design of the survey, which features several rounds of interviewing covering 2 full calendar years, makes it possible to determine how changes in respondents' health status, income, employment, eligibility for public and private insurance coverage, use of services, and payment for care are related. Because the data are comparable to those from earlier medical expenditure surveys, it is possible to analyze long-term trends.

State Perspective: The MEPS-HC is a well-designed and tested household survey. Unfortunately, there is not enough sample to produce state estimates of the uninsured. National data on medical expenditures may be used to model state expenditures in select categories, but states, in general, are reluctant to use data that do not reflect the unique characteristics of their state and its population. Access to the micro-data (i.e., individual household data) is hindered by a complex process designed to provide data privacy protections. Details on how to access the data through Census Research Data Centers are discussed in more detail in the following section.

Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)

<http://www.meps.ahrq.gov/>

The MEPS Insurance Component (IC) consists of two subcomponents, the household sample and the list sample. The household sample collects detailed information on the health insurance held by and offered to respondents to the MEPS-HC. The number of employers and union officials interviewed varies from year to year, as the number of respondents in the previous year's HC varies. These data, when linked back to the original household respondent, allow for the analysis of individual behavior and choices made with respect to health care use and spending. The list sample consists of a sample of business establishments and governments throughout the United States. Cost constraints prevent the fielding of a sufficiently large sample to provide state estimates for all 50 states and the District of Columbia every year. In 1996, estimates were made for the forty most populated states. Beginning in 1997, a sample rotation strategy was implemented so that the 20 least populated states will receive an adequate sample size to make state-level estimates at least once every four years. (For additional information on the sample rotation, please see: <http://www.meps.ahrq.gov/MEPSDATA/ic/1999/technote.pdf>). MEPS-IC

may be used to produce national, regional, and state-level estimates of the amount, types, and costs of health insurance available to Americans through the workplace.

State Perspective: Like the Household Component, the MEPS-IC is a well-designed and tested survey. It includes state identifiers and sufficient sample size to produce state estimates for most states. The cross tabs that have been published for a subset of states represent a good start in making the survey results available. However, more analysis could be done with these data. For instance, states are interested in employee offerings in rural versus urban areas, by firm size, cost sharing requirements, availability and amounts of preventive services and prescription drug coverage. These data are collected but are not included in the public tables. It should be noted that AHRQ has provided additional one-time runs for states by request, but time and resources may limit their ability to respond to state-specific data needs. Perhaps a more important issue for states is that the data currently released are for 1996, which may not adequately represent a state's current employment-based health insurance trends. In addition, the use of MEPS for state analysis is not well publicized. Our state analyst interviews revealed that many state analysts were unaware of MEPS or that state tables had been released with descriptive results for the Insurance Component.

Access to MEPS-IC Data through Census Research Data Centers

The possibilities for state policy research are largely untapped by states that are aware of MEPS because access to micro-data analysis is too costly and cumbersome for state policy needs. Researchers who would like to conduct their own analyses of the MEPS IC data must: (1) submit a proposal for review by the Office of the Chief Economist at the Census, the AHRQ; (2) receive security clearance to access Census data; and (3) physically go to a Census Research Data Center (RDC)⁴. There are six RDCs across the country: Washington DC, Boston, Pittsburgh, Los Angeles, Berkeley and a newly established center at Duke University in North Carolina. The proposal review process takes approximately two months and is conducted concurrently by Census and AHRQ.

Once a proposal has been accepted, the researcher must "buy time" on an RDC computer to run analyses or pay a programmer consultant to run programs. Anyone who enters an RDC must obtain "Special Sworn Status" (SSS) which includes a background check, security clearance, and analysts must sign and make a sworn statement about preserving the confidentiality of the data⁴. Individuals who violate this agreement are subject to the same criminal penalties as Census Bureau employees who violate the confidentiality of the data. The time and money required to use MEPS-IC make it infeasible for many states. Only three of the fifteen states we interviewed have used MEPS-IC. Furthermore, it is not clear that the detailed analyses states want could be generated and released given Census concerns of data privacy and confidentiality.

National Health Interview Survey (NHIS)

<http://www.cdc.gov/nchs/nhis.htm>

The National Health Interview Survey (NHIS) is a continuing nationwide survey of the U.S. population. The sample includes 36,000 to 47,000 households each year. Interviews are

conducted by trained personnel of the U.S. Bureau of the Census to obtain information about the health and other characteristics of each living member of the sample household. Data collected includes the number of work- or school-loss or restricted-activity days, as well as all physician visits occurring during the 2-week period prior to the week of the interview.

State Perspective: The advantage of NHIS data is that it is an established ongoing survey with federal funding. It includes surveys of households with and without telephones so it is more likely to reach low-income populations. Public use files are available and easy to obtain. The NHIS micro-data is now available through NCHS' own Research Data Center, which was modeled after the Census RDCs and has a similar process as Census for accessing data⁵. Release of data is comparable to other federal surveys, which appears to be on average two years from data collection.

The disadvantages of NHIS are that it is not specifically designed to produce state estimates and because it is such a comprehensive survey, it would be costly to add enough sample to do so. At least one state (CA) considered buying into NHIS but for specific issues related to the sampling frame for NHIS, decided to conduct their own household survey and try to build in some of the NHIS questions. It is not impossible to produce state estimates from NHIS but it is not easy to do. States may apply their own demographic population counts to the NCHS published weights to produce state-level estimates and directions for this process are published with the 1994 public use file. The process used to compute these calculations takes time and a certain level of statistical knowledge and expertise. Another disadvantage of NHIS is that prior to 1997, the uninsured are counted as those who do not report any other type of coverage, like the CPS and SIPP⁶. That is, uninsured status serves as a residual category, which may lead to overestimating the number of uninsured.

State and Local Area Integrated Telephone Survey (SLAITS)

<http://www.cdc.gov/nchs/slait.htm>

The State and Local Area Integrated Telephone Survey (SLAITS) is a mechanism for government agencies and nonprofit organizations to sponsor or “buy into” for data collection in areas ranging from health insurance coverage and access to care to perceived health status and utilization of services to measures of child well being. SLAITS uses the same random-digit-dial telephone design approach and sampling frame as the ongoing National Immunization Survey conducted by the Centers for Disease Control and Prevention (CDC.) It allows researchers to collect data using customized questionnaires and the National Immunization Survey sampling frame of nearly one million households (NCHS 2001). There are presently four existing SLAITS survey modules including: Health (Iowa and Washington State, 1997), Child Well-Being and Welfare (Texas and Minnesota, 1998-99), National Survey of Early Childhood Health (national sample, 2000), and Children with Special Health Care Needs (national and state samples, 2000-01).

State Perspective: SLAITS has the potential to provide a mechanism for state and national comparisons of data and for customization to accommodate state-specific needs. Data collection for three pilot states (MN, IA, NM) was conducted in 1997 and it has gone through significant

design work and statistical modifications. For example, to correct for under-reporting of public programs typically seen in household surveys, NCHS developed a study in two states using people they knew had recently left Medicaid and to produce a statistically sound correction for this under reporting. They have also developed methods to correct for bias inherent in telephone surveys for low-income respondents. (Edward L. Hunter, Associate Director for Planning, Budget and Legislation, National Center for Health Statistics, Center for Disease Control, personal conversation, January 14, 2000.)

The present downside to SLAITS is that it has not secured ongoing funding and future funding is uncertain. It appears that SLAITS may seek project-specific funding from outside sources as opposed to ongoing core NCHS federal funds. For example, the Health Resources and Services Administration (HRSA) is currently using some portions of the SLAITS survey and a modified sampling frame to conduct a large study of children with special health needs in all 50 states. Access to the micro-data, if and when collected, will be available through NCHS' own Research Data Center, which may present issues for states unless the discussions of off-site access are feasible. The SLAITS project must compete with other NCHS activities in the federal budget process and it is not clear that a state-focused survey can successfully compete in a federal budget context.

Survey of Income And Program Participation (SIPP)

<http://www.sipp.census.gov/sipp/>

The Survey of Income And Program Participation (SIPP) is conducted by the U.S. Census Bureau to collect information about the labor force behavior, income, participation in public programs, basic demographic characteristics to measure the effectiveness of existing federal, state, and local programs. In addition, the data are used to estimate future costs and coverage for government programs, such as food stamps, as well as to provide improved statistics on the distribution of income in the country. The survey is a continuous series of national panels, with sample size ranging from approximately 14,000 to 36,700 interviewed households. The duration of each panel ranges from 2 1/2 years to 4 years.

State Perspective: SIPP does not allow for state-level estimates and increasing the sample has significant cost implications⁷. In addition, the release of SIPP data is 18+ months from data collection. This time period may be more reasonable from a federal survey perspective, than it is from a state policy perspective where decisions often need to be made in a short time frame. Another downside to SIPP, which is consistent with other general population surveys, is that it may under-report Medicaid⁸. SIPP is presently the best data set for analyzing the dynamics of the uninsured over a long period of time, which may provide a starting point for states interested in learning more about the episodic nature of uninsurance⁹. However, its inability to furnish state-level estimates makes its practical application limited.

Community Tracking Study Household Survey

<http://www.hschange.com/index.cgi?data=01>

The Community Tracking Study (CTS) is a longitudinal study of health system change and its effects on people. One component of the CTS is the Household Survey, which is a biennial, national telephone survey in 60 randomly selected communities stratified by region, community size and type (metropolitan and non-metropolitan). Table 2 lists the 60 communities by state and highlights 12 communities where more in-depth data collection and analysis is being conducted. The Household Survey sample includes 60,000 individuals in 33,000 families. The survey focuses on assessing whether consumer access to the health care system is improving or declining over time, nationally and at the community level. Particular areas of inquiry include access, satisfaction, use of services and insurance coverage. Information about health status and sociodemographic characteristics is also collected.

State Perspective: The concern, from a state perspective, is how the community-level data ties to state trends or informs state policy. The data collected for the communities in CTS information may be compared to other communities in the sample, but the broader state applications are not clear. States may be less interested in local and regional estimates of uninsurance coverage, but they are generally interested in the context of broader state policy and in identifying pockets of concern or needed local interventions. In addition, like many surveys, it under reports Medicaid participation⁶.

Table 2. Communities Included in the Community Tracking Study by State

State	Sites/Geographic Regions
ALABAMA	Dothan, W-Cen Alabama
ARKANSAS	Cen Arkansas, Little Rock
ARIZONA	Phoenix
CALIFORNIA	Los Angeles, Modesto, Orange County, Riverside, San Francisco, Santa Rosa
COLORADO	Denver
CONNECTICUT	Bridgeport
FLORIDA	Miami, Tampa, W Palm Beach
GEORGIA	Atlanta, Augusta, N Georgia
ILLINOIS	Chicago, NE Illinois
INDIANA	Indianapolis, NE Indiana, Terre Haute
LOUISIANA	Shreveport
MASSACHUSETTS	Boston, Worcester
MARYLAND	Baltimore
MAINE	E Maine
MICHIGAN	Detroit, Lansing
MINNESOTA	Minneapolis
MISSOURI	St. Louis
NORTH CAROLINA	E North Carolina, Greensboro, Wilmington
NEW JERSEY	Middlesex, Newark
NEVADA	Las Vegas
NEW YORK	Nassau, New York City, Rochester, Syracuse
OHIO	Cleveland, Columbus
OKLAHOMA	Tulsa
OREGON	Portland
PENNSYLVANIA	Philadelphia, Pittsburgh
SOUTH CAROLINA	Greenville
TENNESSEE	Knoxville
TEXAS	Houston, Killeen, San Antonio
UTAH	N Utah
WASHINGTON	NW Washington, Seattle
WASHINGTON, DC	Washington DC
WISCONSIN	Milwaukee
WEST VIRGINIA	Huntington

National Survey of America's Families (NSAF)

<http://newfederalism.urban.org/nsaf/>

The **National Survey of America's Families** produces quantitative measures of quality of life for people under age 65 in 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. These states were chosen because they represent a broad range of fiscal capacity, child well being, and approaches to government programs. The survey provides a particular focus on health insurance coverage.

State Perspective: The 13 states where the NSAF is fielded benefit from a well-designed survey focusing on health coverage issues. In addition, low-income households have been oversampled and efforts to include households without telephones have generated enough sample to provide estimates of some populations of color and immigrants. The Urban Institute has made the micro-data for the 1997 and 1999 NSAF available to states for additional analyses. The usefulness of privately funded surveys in the long run is essentially tied to the availability of funds for additional follow-up surveys. There have been discussions between Urban and several states to effectively "buy-in" to NSAF in place of a state's own household survey. To date, no states have signed on to a "buy-in" proposal. The usefulness of privately funded surveys in the long run is essentially tied to the availability of funds for additional follow-up surveys.

1993 Robert Wood Johnson Foundation Family and Employer Health Insurance Surveys

The 1993 Robert Wood Johnson Foundation (RWJF) household survey was conducted in 10 states and provided new, detailed data on the uninsured in those states. It was one of a few household surveys that went door-to-door in an effort to reach individuals without phones, thus potentially increasing the accuracy of its uninsurance estimates. It was also one of the only sources of state-level data on insurance coverage for populations of color. Like the household survey, the employer survey was a well-designed survey that provided invaluable information to the 10 participating states. Several states pursued adding state sample to the next iteration, which was a nationally representative sample, and now have two points in time to measure change. For example, the State of Minnesota used these data to take a comprehensive look at changes in the employer market between 1993 and 1997¹⁰.

State Perspective: These surveys provided a wealth of information about the uninsured, as well as about the insurance offered by employers for individuals in the 10 states in which the surveys were conducted. Several years later, one of the states included in the survey, was still using the estimates from this survey for its insurance coverage for populations of color, as its own state-initiated survey did not have the sample size needed for sub-population estimates. Several states were able to obtain the RWJF survey micro-data as long as data confidentiality requirements were met. For most states, there were no follow-ups to the 1993 survey and it became a point-in-time look at insurance coverage with no ability to measure or monitor change over time in

insurance estimates. It is unlikely that a national organization or the federal government would perform this level of detailed analysis. The drawbacks of the employer survey are that there is no planned follow-up survey and it was conducted initially in only 10 states.

1. CDC. About the BRFSS. Centers for Disease Control and Prevention; 1999.
2. Figgs LW, Bloom, Y., Dugbatey, K., Stanwyck, C.A., Nelson, D.E., Brownson, R.C. Uses of Behavioral Risk Factor Surveillance System Data, 1993-1997. *American Journal of Public Health*. 2000;90:774-776.
3. Nelson CT. Current Population Survey. *Obtaining State Estimates on the Uninsured*. Annapolis, MD. Robert Wood Johnson Foundation; 2000.
4. Census. The Research Data Center (RDC) Program, U.S. Bureau of the Census; 1999.
5. NCHS. NCHS Research Data Center. NCHS; 2000.
6. Lewis K, Ellwood, M., Czajka, J.L., Mathematica Policy Research, Inc. Counting the Uninsured: A Review of the Literature. Washington, D.C.: The Urban Institute; 1998:1-31.
7. Kalton G. SIPP Quality Profile 3rd Edition. Washington, D.C. U.S. Bureau of the Census; 1998:1-1 through 11-6.
8. Bennefield RL. A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP. *1996 Joint Statistical Meetings of the American Statistical Association*; 1996.
9. Swartz K. Dynamics of People Without Health Insurance: Don't Let the Numbers Fool You. *JAMA*. 1994; 271:64-66.
10. Sonier J. Employer-Based Health Insurance in Minnesota. St. Paul: Minnesota Department of Health, Health Economics Program; 2000:1-69. <http://www.shadac.org/publications/pubs.htm>